NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE
APPLICATION FOR PROVIDER ENROLLMENT

RESIDENTIAL SERVICES

Residential Services providers must file an application for enrollment as a Medicaid provider and sign a provider agreement. A separate application and provider agreement must be completed for **each business site**. The enrollment process must be completed and the provider participation agreement approved prior to submitting claims for payment.

_____

Name of Business/Agency

_____ (___)_____

Site Address Phone

_____

City State Zip

_____

Mailing Address (if different from above)

1) Please check the services for which you are applying to provide. Each **site** must have a separate provider number and provider agreement. More than one type of service may be provided at a site if all service definition requirements are met.

Check Desired Service	Required Accreditation Credential	Required License
___ Level II HRI - Residential ___ Level III HRI - Residential ___ Level IV HRI - Residential	Copy of JCAHO, COA, CARF*, Area Mental Health Program or N.C. Division of MH/DD/SAS accreditation showing end date of accreditation period **or** a copy of a current Area Mental Health Program contract showing contract period	Copy of license as required by G.S.122C from the N.C. Division of Facility Services
___ Psychiatric Residential Treatment Facility	Copy of JCAHO, COA, or CARF accreditation showing end date of accreditation period	Copy of license as required by G.S. 122C or G.S. 131E, Article 5 from the N.C. Division of Facility Services

* JCAHO – Joint Commission on the Accreditation of Healthcare Organizations
COA – Council on Accreditation of Services for Families and Children
CARF – Rehabilitation Accreditation Commission

2) Number of beds in the residential placement: _____

3) Is the placement state-owned: ( ) Yes ( ) No

4) Is the residential placement hospital-based? ( ) Yes ( ) No

Name of associated hospital: _____

5) Have individuals or organizations having a direct or indirect ownership or control interest of 5% or more in this business been convicted of a criminal offense related to the involvement of such persons or organizations in the programs of Medicaid (Title XIX), Medicare (Title XVIII or Social Services Block Grant (Title XX)?

____ Yes (Provide names in this space or attach documentation.)

____ No

6) Have any directors, officers, agents, or managing employees of the agency or organization been convicted of a criminal offense related to their involvement in the programs of Medicaid, Medicare, or Social Services Block Grant?

____ Yes (Provide names in this space or attach documentation.)

____ No

SIGNATURE OF PROVIDER:

_____

Printed Name of Owner or Corporate Officer Title

_____

Signature of Owner or Corporate Officer

Please enclose a copy of the applicable accreditation credential and license with a completed provider participation agreement and mail to:

Provider Services
DMA
2506 Mail Service Center
Raleigh, NC 27699-2506

9/00